Dr. Clark Ryan Konczak: Chiropractic Corporation:
B.Sc., DC, ICSSD, Grad Cert Sports Chiro, Grad Cert Msk Mgmt, M.Sc.
Board Eligible- American Board of Chiropractic Orthopedists,
Resident CCSS(C)

CONFIDENTIAL PATIENT INFORMATION

We wish to provide you with the best chiropractic care available. Please be neat and as complete as possible.
The more information we have, the better we can understand your condition.
Although no specific result can be guaranteed, our goal is complete satisfaction so that you will wish to refer others.

Name:_________________________ Birthdate:_____________ CareCard#:________________

Address:____
(#, Street, City, Postal Code)

Email (work and home):____
We will send you only changes to Dr. Konczak's office hours and Holiday schedule. NO SPAM

Home Phone ________________Business Phone________________Cell Phone:________________

Medical Doctor______________________________ Date of last visit to MD____________________

Is this an ICBC? YES / NO Claim # ____

Is this a work injury (WCB)? YES/ NO Claim # ___________________________________

Adjuster's name__________________________________Date of injury____________________

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS & CARE

Doctors of chiropractic, medical doctors and physiotherapists who use manual therapy techniques such as spinal adjustments are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

a) While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following spinal adjustments;

b) There have been reported cases of injury to a vertebral artery following cervical spinal adjustments. Vertebral artery injuries have been known to cause stroke, sometimes with serious neurological impairment, and may on rare occasion result in serious injury or death. The possibility of such injuries resulting from cervical spinal adjustments is extremely remote;

c) There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustments although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment. Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be a highly effective treatment for spinal pain, headaches and other similar symptoms. Chiropractic care contributes to your overall well-being. **The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.**

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

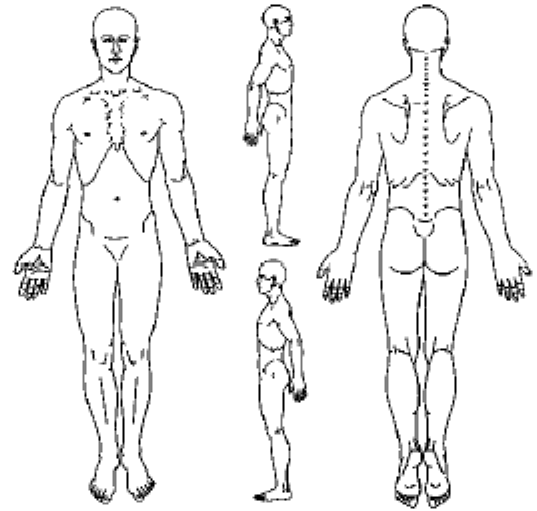
Dr. Konczak and staff have my permission to call and/or leave messages for me at the above listed contact information.

I am 19 years of age or older.
I understand the above information. (Please sign this after talking to Dr. Konczak)

Signature________________________________Date_________________________

Witness________________________________ (Dr. Clark Konczak)

What is the reason for your visit?____________________________



Please indicate on the picture the location of your complaint.
What treatment have you tried for this including medications.
____
When did this condition start?______________________________
Has it occurred before? YES / NO
How did it happen?_________________________________
Is it related to job or auto accident? JOB AUTO No
What makes it feel worse?____________________________
What makes it feel better?____________________________
Since it started, is it getting better or worse? Better / Worse

PAST HEALTH AND INJURIES

Motor Vehicle Accidents? YES / NO
What? Dates?____________________________________
Work Injuries? YES / NO
What? Dates?____________________________________
Sports Injuries? YES / NO
What? Dates?____________________________________
Have you ever injured your head or lost consciousness? _YES / NO

Have you seen a chiropractor before? YES / NO Whom?_____________________When?__________
Have you had X-rays taken for your area of complaint? YES / NO When?______________Where?__________
Past Hospitalizations/ or major illness:____
Surgeries and Operations:____
Are you on any Medications/vitamins/over the counter drugs/ birth control?:________________________
Any Allergies?____

DO YOU HAVE A FAMILY HISTORY OF? (Please Circle)

Back/Neck Pain Cancer Diabetes Heart Problems High Blood Pressure Stroke

4. DO YOU? (Circle and fill in)

Smoke or chew Tobacco: Yes I Currently Smoke____pk/day for____years;
NO, BUT I USED TO. Quit how long ago? ______ How much back then?________
NEVER
Alcohol: How many glasses of beer/ wine/ spirits per week?___________
Interrupted sleep It has been interrputed____times/night for____months/years.

IS YOUR REASON FOR THIS VISIT ALSO WORSENING YOUR SLEEP? YES / NO

5. REVIEW OF SYSTEMS

Please **circle** the symptom if **YOU PRESENTLY HAVE** it or have had MAJOR PROBLEMS with it in the past.

General: **Fever, chills, recent weight gain/loss, anemia, fatigue, bleeding abnormalities, night sweats.**
Head: *Frequent or severe headaches/ migraine,* ***when did they begin?_________,****head injury*
Eyes/Ears: **Changes in vision/ Changes in hearing loss/ ear problems/ ringing in ears**
Nose/Mouth: *Change in smell/nose bleeds/ infections/ allergies/ Change in taste/ difficulty speaking*
Chest: **Persistent cough/ Difficulty breathing/ asthma/ frequent infections/ Chest pain/ angina/ heart murmur/ heart attack/ rheumatic fever/ high or low blood pressure/ high cholesterol or lipids/ phlebitis or blood clots/ swelling in ankles/ hardening of the arteries**
GI: *Black stools/ rectal bleeding/ colitis/ diverticulosis/ diarrhea/ constipation/ changes in appetite*
GU: **Blood in urine/ painful, frequent urination/ prostate problems/ bladder, kidney infections**
Neurological: *Seizures/ fainting/ stroke/ dizziness/ numbness/ weakness/ tremors*
Musculoskeletal: Arthritis/ gout/ osteoporosis/ spinal curvature/ sciatica/ pain or numbness in hand, arm, shoulder, hip, knee, leg, ankle
Other: *Anxiety/ depression/ insomnia/ Diabetes/ thyroid disease/ Cancer/ Tuberculosis(TB)/ hepatitis/ HIV (Aids)/ infectious disease*

Is there anything else not covered here that the doctor should be aware of? NO / YES (Write Below)